DEPARTMENT OF FINANCE
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March 8, 2007

Mr. Stephen W. Mayberg, Ph.D., Director
California Department of Mental Health
1600 Ninth Street, Room 151
Sacramento, CA 95814

Dear Dr. Mayberg:

Final Report: Review of the Department of Mental Health's Early and Periodic Screening, Diagnosis and Treatment Program's Estimation Process

Enclosed is the final report on our review of the annual estimation methodology of the Department of Mental Health's (Department) Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). The Department of Finance, Office of State Audits and Evaluations, performed this review in accordance with an interagency agreement with the Department.

We appreciate the Department's assistance and cooperation with this review. If you have any questions, please contact Diana Antony, Manager, or Zach Stacy, Supervisor, at (916) 322-2985.

Sincerely,

Original Signed By:

Diana L. Ducay, Chief
Office of State Audits and Evaluations

Enclosure

cc: Mr. Scott Carney, Assistant Secretary, Health and Human Services Agency
Ms. Terrie Tatosian, Deputy Director, Administration, California Department of Mental Health
Mr. Rollin Ives, Deputy Director, Program Compliance Division, California Department of Mental Health
Ms. Harriet Kiyan, Chief Financial Officer, California Department of Mental Health
Mr. John Doyle, Principal Program Budget Analyst California Department of Finance
Mr. Jim Alves, Staff Finance Budget Analyst, California Department of Finance

A SPECIAL REVIEW

Report on the Department of Mental Health

Review of the Early and Periodic Screening, Diagnosis and Treatment Estimation Process

Prepared By:
Office of State Audits and Evaluations
Department of Finance

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February 2007

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EXECUTIVE SUMMARY

The Department of Mental Health's (DMH) forecasting of resource requirements for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program has consistently been underestimated and DMH has not been able to adequately explain the causes. The DMH requested the Department of Finance, Office of State Audits and Evaluations, to review and document the current EPSDT estimate methodology, identify best practices utilized by other agencies or states, and provide recommendations for improvement. The review identified the following weaknesses in DMH's current process and best practices that if adopted would improve the current EPSDT estimate methodology:

- Currently, DMH's base expenditure projection is based on regressed historic costs at the program level and does not incorporate specific user and service level data. In all the other models reviewed, the base estimate was a sum of regressed historic costs of various user and service category levels. By not incorporating user and service type categories, DMH is unable to isolate variances between actual and projected costs or adequately assess implications of new mandates or other policy changes. DMH cited a number of challenges, including limited data currently available and inconsistently coded data reported by the counties. Accordingly, DMH was unable to provide a revised estimate for the current period using the essential user and service detail. We recommend DMH break down service type categories into more detailed relevant component levels and prepare the EPSDT base estimate at the component level. Additionally, we recommend DMH implement a uniform claim coding system to ensure county approved claims are consistently coded and include the desired service type categories.

- The cost settlement factor used to adjust the EPSDT base estimate should be reevaluated. DMH develops a cost settlement factor using three year county-wide data. Annual cost settlement ratios have consistently increased over a three year period, approaching 100 percent. However, the three year average used by DMH is currently 94.2 percent. Therefore, by using a three year average DMH is not considering the apparent upward trend. Additionally, the data used is almost three years old and may not reflect current cost settlement activities. We recommend DMH reevaluate the accuracy of the current discount factor in their estimate calculation and/or adopt a new methodology to accurately estimate the cost settlement trends.

- DMH is not proactive in identifying potential policy change impacts to the EPSDT program. Historically, DMH has not adequately assessed future changes to the EPSDT program and how changes will impact the EPSDT resources needed. We recommend DMH develop a methodology, which would quantify and incorporate future policy changes to the EPSDT estimate.

- Potential increases in existing prevalence rates are not adequately assessed. The fiscal year 2006-07 estimated cost for California's EPSDT program was less than $1 billion annually. This cost could exceed $3.35 billion annually should prevalence rates reach

their potential. We recommend DMH consider increase in caseloads, users, and other eligibility factors that may impact the program and incorporate into the estimate methodology.

Moving forward, DMH should develop a plan to address the estimate methodology's observations and recommendations noted in this report. However, based on the magnitude of revisions and the expertise required, it is strongly recommended that DMH engage the services of an independent consulting group.

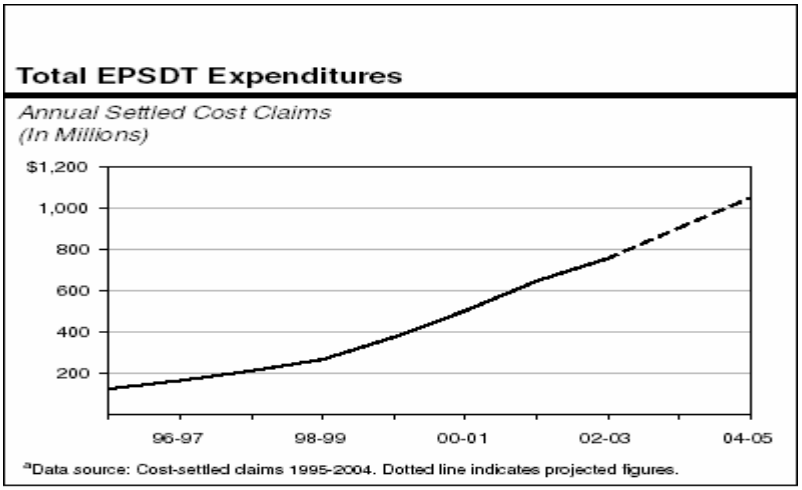
BACKGROUND, SCOPE AND METHODOLOGY

BACKGROUND

Medi-Cal's child health component, known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program has been shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of low-income children. Since 1967, the purpose of the EPSDT program has been "to discover, as early as possible, the ills that handicap our children" and to provide "continuing follow up and treatment so that handicaps do not go neglected." In 1995, in response to legal action, the California Department of Health Services (DHS) expanded the Mental Health portion of the EPSDT benefit to full-scope Medi-Cal beneficiaries less than age 21.

In its implementation of the expanded Mental Health EPSDT benefits, DHS recognized that county mental health departments had been the historic providers of mental health services since passage of the Short Doyle Act in 1957. Accordingly, county mental health departments were determined to be the logical choice to provide the expanded EPSDT benefit to the Severe Emotional Distress (SED) population. When specialty mental health services were consolidated under a federal waiver in fiscal year 1997-98, county mental health plans assumed the responsibility to provide these services to all Medi-Cal children and youth meeting the medical necessity criteria, in addition to the SED population already being served.

DHS developed an interagency agreement with the Department of Mental Health (DMH) in which county mental health plans are reimbursed the entire non-federal share of costs for all EPSDT-mental health eligible services in excess of the expenditures made by each county for such services during fiscal year 1994-95 (the baseline). Growth in number of clients, amount of services provided, and expenditures for the mental health portion of the EPSDT benefit has been rapid (see chart).



Source: Prepared by the LAO for use in their Analysis of the 2004-05 Budget Bill. Final settled claim figures are not available after 2002-03 because of the pending cash to accrual adjustments requested by DMH.

This growth reflects the interpretation of a broader definition of medical necessity under title 19 of the Social Security Act [42 U.S.C. 1396d] to "correct or ameliorate." Additional impacts include new state mandates for services such as therapeutic behavior services and mandatory foster care assessments.

DMH's forecasting of resource requirements for the EPSDT program has consistently been underestimated causing repeated deficiency requests through the budget revision process. Furthermore, DMH has been unable to adequately account for the causes of underestimates.

SCOPE

In an effort to identify the causes of underestimates, DMH requested the Department of Finance, Office of State Audits and Evaluations, to review the current estimate process. Specifically, the objectives of this review included:

- Document the current EPSDT program estimate methodology.
- Identify best practices for the EPSDT program estimate methodology.
- Make recommendations to improve the current EPSDT estimate methodology.

In gaining an understanding of the current EPSDT methodology, our scope did not include a review or assessment of data supplied by the counties, a detailed analysis of EPSDT program eligibility requirements, or a review of EPSDT controls and processes in place. Additionally, we did not employ an expert in statistical analysis and did not evaluate the statistical software or programs used. Finally, the review of other states' methodologies was limited to a survey rather than an in depth analysis of their programs, and our analysis was limited to those states that were willing to complete our survey in a timely manner.

METHODOLOGY

To document the current EPSDT program estimate methodology, we conducted interviews with the DMH management and staff directly responsible for the administration of the program, including the forecasting process. We also reviewed EPSDT program regulations and DMH policies and procedures.

To identify best practices, we reviewed the estimate methodologies used by the Department of Health Services' (DHS) Medi-Cal program, the Department of Developmental Services' (DDS) Regional Center Local Assistance program, and other states' EPSDT programs outside of California. Entities were selected because they had fiscal responsibility for large mandated health care programs and cope with similar user demographics. We conducted interviews with key personnel from DHS and DDS to obtain an understanding of their current estimate methodologies. To obtain non-California EPSDT information, the ten largest states (after California) were selected based upon the number of individuals under the age of 21 enrolled in the states' respective Medicaid programs. Of the ten states contacted, five agreed to respond to a structured questionnaire, for an overall response rate of 50 percent.

This review was conducted during the period November 2006 through February 2007.

OBSERVATIONS and RECOMMENDATIONS

An evaluation was performed of Department of Mental Health's (DMH) current estimate methodology for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program in comparison with best practices of other entities.

DMH's current forecast model estimates future program expenditures based on prior year EPSDT claims history. The Forecast of Approved Claims (base estimate) is derived from a 36-month historical trend analysis (using statistical software) of approved county claim data extracted from the Short-Doyle/Medi-Cal System (SDMC). The base estimate is then adjusted for cost settlement activities (to determine actual claims paid), federal and county shares of program costs, and a county baseline adjustment. In addition, DMH also adjusts the baseline for audit (chart review) recoupments, disallowed claims, and for fiscal year 2006-07, cash to accrual and prior year unpaid claim adjustments, all of which were not included in the scope of this review. Exhibit I illustrates DMH's current estimate, including adjustments for fiscal year 2006-07 and 2007-08. For an in-depth narrative of the estimate methodology, see Exhibit II.

In determining best practices, we reviewed the estimation practices employed by selected California agencies and a representative selection of other states' respective EPSDT programs. These programs were selected because they oversee large mandated health care programs. Other states' EPSDT program reviews were selected based on states whose program eligibles were comparable to California. Specifically, we reviewed the estimate methodologies of the California Department of Health Services' (DHS) Medi-Cal program, California Department of Developmental Services' (DDS) Regional Center Local Assistance program, and the EPSDT estimate methodologies for Texas, Florida, Ohio, Tennessee, and Michigan. In selecting other California department's estimation processes, we realized the size of the programs administered by DHS and DDS are not similar to DMH's EPSDT program, however, they are similar in the types of services provided. For additional detail of the estimate methodologies reviewed, see Exhibit III.

Based on our analysis, we identified several estimate methodologies that we consider best practices. Our observations of DMH, DHS, DDS and the other states' respective programs are summarized on the table below:

Variables Utilized in Forecasting

State or Agency	Program Level	Sub-Program Level (User and Service Components)	Policy Changes	Changes in Eligible Individuals	Changes in Prevalence Rates
DHS		✓	✓	✓	✓
DDS		✓	✓	✓	✓
Texas		✓	✓	✓	✓
Florida		✓		✓	✓
Ohio		✓	✓	✓	✓
Tennessee		✓	✓	✓	✓
Michigan		✓	✓	✓	✓
DMH	✓				

Each program examined uses historical trends to develop a base estimate. With the exception of Florida, all states reported using a high level of detail in forecasts, stated that using component levels provided additional tools to analyze variances between budgeted and actual amounts, and reported that evaluating policy changes is an essential aspect in forecasting. Additionally, all programs examined indicated that changes in eligibles and participation levels are analyzed on a periodic basis as part of the forecasting process.

Because of the magnitude, DMH would benefit from utilizing the services of an independent consulting group to address the observations and recommendations noted below.

OBSERVATION 1: EPSDT Base Estimate Lacks Essential User and Service Type Components

In all the other models reviewed, the base estimate was a function of the regressed historic costs at the user and service component levels. The DHS, DDS, and most of the state programs reviewed build their base estimate up from the user and service units in order to determine the program level base estimate. For example, DHS runs independent regressions on users, claims/user or units/user, and dollars/claim or dollars/unit for each of the 18 aid categories within 12 different service categories. See Exhibit IV for further detail. Likewise, DDS also extracts data at the historic service category level of the program. However, DDS then provides the information to a consultant group, University Enterprises, Inc. at the California State University, Sacramento to develop a base estimate.

The current EPSDT base estimate is a function of the regressed historic costs at the program level and does not incorporate specific user and service components. By not incorporating user and service type categories, DMH is unable to isolate variances between actual and projected costs.

When asked to provide the lowest level of detail, DMH was only able to provide sub-program level information. A review of the information revealed that the data still lacked the essential user and service detail necessary to develop an adequate forecast.

Tracking costs at the user and service levels, or component units, would allow variances between actual costs and projected costs to be isolated and would provide users and stakeholders with more relevant information. For instance, if the Legislature is considering a bill to expand benefits to a specific category of mental illness, it would be useful to know the current number of cases and statistical trends in order to adequately evaluate the fiscal impact. When variances occur, staff can analyze the variance at the component level and develop future estimate assumptions.

However, DMH expressed doubt that the counties would comply with additional data requests. Furthermore, DMH states that internal claim coding varies from county to county; therefore, even with the raw data from the counties, DMH's currently available cost category detail is limited. While we recognize these challenges, without long-term changes to the current estimate methodology, including data gathering, DMH faces continued program expenditure deficits without an adequate plan for improvement.

Recommendation: Break down service type categories into more detailed relevant component levels and prepare the EPSDT base estimate at the component level. Implement a uniform claim coding system to ensure county approved claims are consistently coded and include the desired service type categories.

OBSERVATION 2: Cost Settlement Adjustments Should be Reevaluated

DMH begins its base estimate by extracting approved claims data from the SDMC system. According to DMH, actual paid claim data is not used because some claims are not paid immediately. DMH attempts to convert the approved claim amount into a paid claim amount by factoring in historical cost settlement rates. Using data at the county level, DMH calculates a cost settlement percentage for each county by dividing the approved claims amount from the SDMC system by the settled claims amount from the county's data system. This factor is averaged over a three year period, and then averaged statewide to create a statewide average percent for cost settlement adjustment. See Exhibit V.

A review of the underlying data revealed that annual cost settlement ratios have consistently increased over a three year period, approaching 100 percent (full settlement of approved claims). For example, the settlement ratio for 2001-02 is 92.9 percent while the ratio for 2003-04 is 97.7 percent. However, the three year average used by DMH is 94.2 percent. Therefore, by using a three year average DMH is not considering the increase reflected from year to year. Finally, the data used is almost three years old and may not reflect current cost settlement activities.

Recommendation: DMH should reevaluate the accuracy of the current discount factor in their estimate calculation and/or adopt a new methodology to accurately estimate cost settlement trends.

OBSERVATION 3: Policy Changes to the EPSDT Program Are Not Adequately Assessed

A review of best practices also noted that tracking the historic data at the component level was helpful when considering the implications of a new mandate or other policy changes. For

example DHS in their fiscal year 2001-02 Medi-Cal estimate, incorporated approximately 101 policy changes that were identified as having a future impact on the Medi-Cal program.

Historically, DMH has not adequately assessed policy changes to the EPSDT program and how changes will impact the EPSDT resources needed. For example, in November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), a measure imposing a new state income tax surcharge to finance an expansion of community mental health services. MHSA will provide counties with additional funding that may expand services to their eligible populations. These expanded services to EPSDT beneficiaries must be paid for by the EPSDT program, which would increase EPSDT program costs. DMH added $20,390,000 and $22,837,000 for fiscal years 2006-07 and 2007-08, respectively, to quantify the effects of the MHSA program on the EPSDT costs. Although DMH stated that the amounts were derived from the county's three-year plans, DMH was unable to explain or provide documentation to support the accuracy of these amounts.

Recommendation: Develop a methodology, which would quantify and incorporate future policy changes into the EPSDT estimate.

OBSERVATION 4: Potential Increases in EPSDT Prevalence Rates Are Not Adequately Assessed

DMH generally does not consider increase in caseloads or other eligibility factors that may have an impact on the program. Currently, EPSDT mental health benefits are utilized by 5.5 percent[1] of Medi-Cal eligible beneficiaries under age 21. According to the Surgeon General's Conference on Mental Health (2000), prevalence estimates of youth (ages 1-19) with emotional and behavioral problems range from 16 to 22 percent. While we recognize that the 1-19 year old group is a subset of the under 21 EPSDT eligibility threshold, the implication that there are many untreated eligible children in the population cannot be ignored.

In fiscal year 2004-05, EPSDT mental health program spending was approximately $4,535[1] per client, per year, with Medi-Cal eligible (and therefore EPSDT eligible) children under age 21 totaling 3,356,524. Using the 16 percent prevalence rate multiplied by the 3,356,524 EPSDT eligible children would result in 537,044 potential clients in need of mental health services under the EPSDT program. Using the $4,535 average cost per year, per client, would mean that program exposure would be approximately $2.44 billion annually without accounting for inflation or mandated program expansions. A 22 percent prevalence rate would result in 738,435 potential clients eligible for EPSDT services and program expenditures in excess of $3.35 billion annually. The fiscal year 2006-07 estimated cost for California's EPSDT program was less than $1 billion.

Therefore, the risk to the state General Fund, should prevalence rates reach their potential, is significant. Because there is potentially a significant population of eligible clients not currently utilizing the EPSDT services, it is imperative to monitor changes in the number of clients (users). This will allow DMH to identify increases in program utilization and costs in a more expedient manner.

Recommendation: Consider increase in caseloads, users, and other eligibility factors that may impact the program and incorporate into the estimate methodology.

[1] "Short-Doyle/Medi-Cal Unduplicated Clients for Early and Periodic Screening, Diagnosis and Treatment Services Report for fiscal years 1994-95 through 2006-07", provided by Department of Mental Health.

CONCLUSION

The Department of Mental Health's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) estimate methodology lacks critical user and service type detail. The present methodology does not allow for a reasonable accountability of projected program expenditure variances. This lack of detail also prohibits an effective review to determine and quantify the impact of future program and policy changes and future impacts of prevalence rates for the EPSDT program. Although DMH indicated that more relevant data was tracked at the county level, DMH expressed doubt that the counties would be willing to provide additional data, and that the current county claim coding system used varied between counties which would further constrain DMH's ability to obtain the essential user and service type detail.

DMH should assess the deficiencies identified in this report and develop a strategic plan to address the observations. In addition, DMH should reevaluate its ability to derive relevant information from the data sources available and consider consulting with Department of Health Services Medi-Cal program to coordinate efforts when practical. In addition, it is strongly recommended that DMH engage the services of an independent consulting group. Whether DMH implements the report recommendations and adopts the identified best practices depends on its ability to make long-term changes necessary to implement a more strategic approach to its current estimation process.

Earl ıd Periodic Screening, Diagnosis and Treatm (EPSDT)

ATT/ ENT B

Change in State funding from the Budget Act of 2006
FY 2007-08 November Estimate

FY 2007-08 November Estimate ***State General Fund (SGF)***	FY 2006-07 Nov	FY 2007-08 Nov
Forecast of Approved Claims (Total FFP + SGF)	1,000,535,894	1,064,763,727
Statewide Average Percent for Cost Settlement Adjustment (% is rounded)	94.2%	94.2%
Total Cost Settled Claims (adjusted FFP + SGF)	942,669,298	1,003,182,475
State Sharing Ratio (Percent for State/Local Match)	50%	50%
State/Local Match (SGF) for forecast claims	471,334,649	501,591,238
MHSA driven EPSDT SGF	20,390,000	22,837,000
Total State General Fund (SGF)/Local Match	491,724,649	524,428,238
Less County Baseline (SGF portion)	(65,818,043)	(65,818,043)
Sub-Total (Additional EPSDT SGF Costs above County Baseline)	425,906,606	458,610,195
Less 10% County Share of Cost	(14,297,979)	(17,323,638)
ACCRUAL--Total State General Fund (SGF) Needed Prior to Audit/DCS Adj	**411,608,628**	**441,286,558**
Plus Accrual to Cash Adjustment (2005-06 claims carried over from previous FY)	107,038,000	
FY 2005-06 Unpaid claims	96,604,640	
FY 2004-05 Unpaid claims	25,677,872	
FY 2003-04 Cost Settlement GF obligation	13,703,647	
Total SGF Needed per November Estimate	654,633,000	441,287,000
SGF Budgeted Authority for FY 2006-07 per Budget Act 2006	**346,428,000**	**346,428,000**
Requested Change in State Funds Prior to Audit/DCS Adjustments	**308,205,000**	**94,859,000**
Adjustments		
FY 2006-07 SGF Audit Recoupment projections	(990,000)	
FY 2006-07 Disallowed Claims System (DCS) SGF projected cash repayment	(4,464,000)	
FY 2007-08 SGF Audit Recoupment projections		(643,000)
FY 2007-08 Disallowed Claims System (DCS) SGF projected cash repayment*		(1,488,000)
Requested Change in State Funds with Audit/DCS Adjustments	**302,751,000**	**92,728,000**
GRAND TOTAL STATE GENERAL FUND Total for FY 2007-08 November Estimate	**649,179,000**	**439,156,000**

*Void and Replace system begins in early FY 2007-08. Void and Replace replaces DCS system.

Nov-06

Source: Department of Mental Health, November Budget Change Proposal.

EXHIBIT I

Narrative of Department of Mental Health's Early and Periodic Screening, Diagnosis and Treatment Forecasting Process

Base Estimate

The first step in the forecasting process is to run a SAS (statistical software) program that creates Month of Service files based on approved claims. The program is run once for each fiscal year that will be included in the forecast. The program extracts the most recent 36 months of data.

The next step in the forecasting process is to use a second SAS program to call in the newly created Month of Service files in order to determine the lag weights that will be applied in the final SAS program. The lag weights are determined by calculating what percent of total claims were approved each month after the month of service. This aggregate percent increases each month until it nears and reaches 100 percent. The lag weights are factored into the most recent six months.

The Department of Mental Health (DMH) uses a STEPAR-Stepwise autoregressive method (employing the linear trend option), which combines trend regression with an autoregressive model and uses a stepwise method to select the lags to use for the autoregressive process. After running the Proc Forecast program, the text file output is brought into a Microsoft Excel file where the forecast tables and graphs are created. The base estimate for approved claims is calculated at a 95 percent confidence level.

Base Estimate Adjustments

Cost Settlement
Once a base estimate for the next 12 months of approved claims is calculated, DMH discounts this amount by approximately 5.8 percent in order to convert the approved claims estimate to an estimated paid claims amount. DMH utilizes the three year statewide average percentage difference between approved claims and cost-settled claims in determining the discount percentage.

State General Fund
DMH then divides the forecast in half to reflect the 50 percent that is paid through the state General Fund.

Local Funding
The EPSDT service and funding levels that existed in fiscal year 1994-95 were established as the county's baseline. If necessary, this baseline is adjusted annually based on Centers for Medicare and Medicaid Services' Home Health Agency Market Basket (HHAMB) index. The HHAMB index is used as a cost of living inflation factor in years where the realignment growth equals or exceeds the index amount.

Starting in fiscal year 2001-02, as an incentive for counties to control costs in excess of the baseline, a ten percent matching requirement was imposed on counties for growth in the cost of EPSDT services. The current budget year's additional EPSDT cost above the current baseline is subtracted from the 2001-02 cost above baseline. The difference is multiplied by the federal sharing ratio. The result is then multiplied by ten percent to establish the county share of growth in the cost of EPSDT services.

The county baseline plus the county's share of growth is deducted from the 50 percent remaining estimate of EPSDT costs. The result is the state General Fund share.

Policy Changes
Although historically DMH has not adequately considered all policy changes, DMH recently factored in an increase to the estimate for the Mental Health Services Act (MHSA). Implementation of the MHSA may increase the number of patients eligible for EPSDT services. Counties were required to submit a three year MHSA Community Services and Supports Program and Expenditure Plan. A component of the plan required counties to estimate additional funding they anticipated to generate as a result of MHSA implementation. DMH used these estimates to factor additional state General Fund resources that will be required for the EPSDT program.

Audit Recoupments and Disallowed Claims
Finally, DMH discounts the state General Fund share by expected chart review (audit) recoupments and other disallowed claims adjustments. The remaining balance is used to estimate the annual state's General Fund resources needed for EPSDT services.

Summary of Best Practices

Department of Health Services
The Department of Health Services (DHS) oversees the Medical Care Services division which is responsible for paying claims for the Medi-Cal program. Medi-Cal is a federally mandated program commonly known as Medicaid. The Department of Health Services, Fiscal Forecasting and Data Management Branch, is responsible for providing statistical health data and producing the Medi-Cal budget estimates. A component of the Fiscal Forecasting and Data Management Branch, the Fiscal Analysis and Estimates Section, is comprised of the Base Estimates and Fiscal Analysis Units.

The Base Estimates Unit develops and operates computer systems and models to estimate base Medi-Cal expenditures. The base estimate represents the anticipated level of program expenditures assuming no changes in program direction. The base estimate is developed using regression equations based on the most recent 36 months of actual data. Thousands of independent regressions are run for various user and service levels within the program. The analysis attempts to identify trends at the component levels of the program: Statewide Eligibles, Managed Care Eligibles, Fee for Service Eligibles and Other Eligibles (Dental, Buy In, EPSDT, Recoveries, etc). The base estimate is then built from the trended component cost projections, which are summed to project the program level base estimate.

The Fiscal Analysis Unit is responsible for quantifying the estimated impacts of any anticipated program changes (i.e. legislation, regulation changes, and federal changes) which impact Medi-Cal local assistance expenditures. In the fiscal year 2001-02 Medi-Cal estimate, there were approximately 101 policy changes that were identified as having a future impact on the Medi-Cal program.

Additional Department of Health Services estimation detail is available at:
http://www.dhs.ca.gov/admin/ffdmb/estimates/

Department of Developmental Services
The Department of Developmental Services (DDS) provides services and support to children and adults with developmental disabilities, consistent with the provisions of the Lanterman Act. These disabilities include mental retardation, cerebral palsy, epilepsy, autism and related conditions. DDS services are coordinated through regional centers which are non-profit private corporations. Offices throughout California provide a local resource to the many services and support available to disabled individuals and their families.

The service and support estimate prepared by DDS also utilizes a base estimate; however, it utilizes the prior six years of claim activity (rather than three years as DHS does) to trend the historic costs. DDS extracts the historic data at the service category level of the program and provides this information to a consultant group (University Enterprises, Inc.) at California State University, Sacramento. University Enterprises, Inc. prepares several regression analyses by service type and or cost category. The base estimate is the summation of this regressed data.

DDS is proactive in identifying non-historical costs that may affect the estimate. Staff will scan local state and federal mandates for potential impacts to the program. As new program changes are identified, they are analyzed, quantified and summed to be incorporated into the program estimate. DDS then sends this data to University Enterprises, Inc. in order to get feedback on the assumptions used to quantify the effects of these changes.

Other States' EPSDT Programs
Ten states were selected based on the number of individuals under the age of 21 enrolled in the state's respective Medicaid programs. Texas, Florida, Ohio, Michigan, and Tennessee responded to the telephone questionnaire. Program budget officers in the Medicaid divisions were asked to select the variables they consider when making their EPSDT forecasts. All of these states indicated that they consider changes in eligible individuals and the participation level of eligible individuals in their estimation methodology. In addition, four of the five states analyze the impact of policy changes and use that information to make any necessary adjustments to their budget forecasts.

The states were also asked to describe the level of detail used when forecasting budgets. Four out of five states indicated that they use detailed categories to breakdown their estimation process, allowing statistical analysis to be performed on each category. These states agreed that the greater detail allows them to better track and manage the overall program.

Department of Health Services
FY 2005-06 MEDI-CAL COMPARE REPORT
MONTH ENDING JUNE 2006

DHS Accounting Reports: Benefits (Medical Care & Services) by Service Category:	CUMULATIVE PAYMENTS - ALL GENERAL FUND ITEMS APPROPRIATION ESTIMATE THRU THIS MONTH	ACTUAL EXPENDITURES THRU THIS MONTH	ESTIMATE SURPLUS/ DEFICIT (-)	PERCENT SURPLUS/ DEF (-)
FEE-FOR-SERVICE:				
PROFESSIONAL	**$1,540,556,000**	**$1,621,146,000**	**-$80,590,000**	**-5.23%**
Physicians	$520,157,000	$548,478,000	-$28,321,000	-5.44%
Other Medical	$765,833,000	$799,819,000	-$33,986,000	-4.44%
Outpatient Total	$254,566,000	$272,849,000	-$18,283,000	-7.18%
PHARMACY	**$1,156,485,000**	**$1,061,507,000**	**$94,978,000**	**8.21%**
Expenditures	$2,066,842,000	$2,182,000,000	-$115,158,000	-5.57%
Rebates	-$910,357,000	-$1,120,493,000	$210,136,000	23.08%
HOSPITAL INPATIENT TOTAL	**$1,917,272,000**	**$1,971,512,000**	**-$54,240,000**	**-2.83%**
LONG-TERM CARE	**$2,135,662,000**	**$1,992,095,000**	**$143,567,000**	**6.72%**
Nursing Facilities	$1,939,246,000	$1,794,168,000	$145,078,000	7.48%
ICF-DD	$196,416,000	$197,927,000	-$1,511,000	-0.77%
OTHER SERVICES	**$605,605,000**	**$605,877,000**	**-$272,000**	**-0.04%**
Medical Transportation	$64,093,000	$70,910,000	-$6,817,000	-10.64%
Other Services	$452,593,000	$451,348,000	$1,245,000	0.28%
Home Health	$88,919,000	$83,619,000	$5,300,000	5.96%
SubTotal - Fee-for-Service	**$7,355,580,000**	**$7,252,137,000**	**$103,443,000**	**1.41%**
MANAGED CARE	**$2,821,085,000**	**$2,784,577,000**	**$36,508,000**	**1.29%**
Two Plan Model/GMC/Other M.C.	$2,033,856,000	$1,982,230,000	$51,626,000	2.54%
Co. Organized Hlth Sys	$787,229,000	$802,347,000	-$15,118,000	-1.92%
DENTAL	**$308,807,000**	**$337,803,000**	**-$28,996,000**	-9.39%
AUDITS & LAWSUITS	**$11,769,000**	**-$25,933,000**	**$37,702,000**	320.35%
EPSDT	**$42,020,000**	**$30,980,000**	**$11,040,000**	26.27%
MEDICARE PAYMENTS[1]	**$1,480,114,000**	**$1,166,738,000**	**$313,376,000**	21.17%
STATE HOSPITALS	**$9,305,000**	**$11,460,000**	**-$2,155,000**	-23.16%
MISC. NON-FFS	**$15,433,000**	**$17,436,000**	**-$2,003,000**	-12.98%
RECOVERIES	**-$118,326,000**	**-$154,007,000**	**$35,681,000**	30.15%
SHORT-DOYLE	**$408,927,000**	**$283,849,000**	**$125,078,000**	30.59%
REIMB./ DSH OFFSETS / CLPP FUNDS[2]	**-$122,926,000**	**-$73,817,000**	**-$49,109,000**	39.95%
APPROPRIATION ADJUSTMENTS[3]	**$22,500,000**			n/a
DHS / SCO RECONCILING ITEMS		**-$7,968,000**		n/a
State Controller's Reports:				
BENEFITS (4260-xxx-0001(3))	**$12,234,288,000**	**$11,623,255,000**	**$611,033,000**	**4.99%**
F.I. - ADMIN (4260-xxx-0001(2))	$97,136,000	$81,367,000	$15,769,000	16.23%
CO. ADMIN. (4260-xxx-0001(1))	$674,432,000	$646,598,000	$29,034,000	4.30%
TOTAL MEDI-CAL FY 2005-06	**$13,005,856,000**	**$12,351,220,000**	**$654,636,000**	**5.03%**

Source: Fiscal Year 2005-06 Medi-Cal Compare Report, Department of Health Services

EXHIBIT V

County of Beneficiary	EPSDT Approved Claims			EPSDT Cost Settled Claims			% Cost Settled of Approved Claims			Three-YR Average
	2001-02	2002-03	2003-04	2001-02	2002-03	2003-04	2001-02	2002-03	2003-04	
Statewide	**703,714,978**	**824,219,444**	**838,739,582**	**653,916,171**	**782,616,118**	**820,067,806**	**92.92%**	**94.95%**	**97.77%**	**94.22%**
Alameda	30,524,283	36,441,679	43,106,215	28,918,706	35,370,294	44,339,053	94.74%	97.06%	102.86%	98.22%
Alpine*	0	0	1,137	0	0	0				
Amador	354,019	453,095	374,864	301,624	424,459	361,856	85.20%	93.68%	96.53%	91.80%
Butte	9,347,702	11,280,179	9,380,955	9,523,439	10,729,706	9,356,565	101.88%	95.12%	99.74%	98.91%
Calaveras	319,431	225,138	226,332	318,537	260,237	281,557	99.72%	115.59%	124.40%	113.24%
Colusa	105,494	229,369	324,934	109,112	270,013	345,242	103.43%	117.72%	106.25%	109.13%
Contra Costa	21,258,584	24,858,671	26,415,988	18,826,602	23,140,937	26,746,188	88.56%	93.09%	101.25%	94.30%
Del Norte	1,330,500	968,281	687,867	1,320,122	974,672	649,897	99.22%	100.66%	94.48%	98.12%
El Dorado	1,543,002	1,630,109	1,723,611	1,628,793	1,772,907	1,981,980	105.56%	108.76%	114.99%	109.77%
Fresno	18,877,806	19,874,288	19,414,208	15,200,409	20,150,541	16,672,922	80.52%	101.39%	85.88%	89.26%
Glenn	1,063,140	766,269	1,247,903	882,619	738,147	1,214,834	83.02%	96.33%	97.35%	92.23%
Humboldt	6,082,940	6,009,391	6,593,692	5,183,881	4,788,884	6,478,302	85.22%	79.69%	98.25%	87.72%
Imperial	3,148,337	4,368,084	4,499,858	2,823,743	4,204,718	4,195,218	89.69%	96.26%	93.23%	93.06%
Inyo	643,231	518,994	472,593	425,755	406,009	356,760	66.19%	78.23%	75.49%	73.30%
Kern	23,654,847	22,823,314	20,909,621	17,336,637	16,820,782	16,844,791	73.29%	73.70%	80.56%	75.85%
Kings	1,878,381	1,871,641	2,235,757	2,123,322	2,048,511	2,348,886	113.04%	109.45%	105.06%	109.18%
Lake	2,260,738	1,524,620	1,318,508	3,091,785	1,590,484	1,024,349	136.76%	104.32%	77.69%	106.26%
Lassen	839,834	1,069,059	1,135,979	822,281	1,395,336	1,188,234	97.91%	130.52%	104.60%	111.01%
Los Angeles	260,875,063	316,150,503	322,866,230	248,092,185	307,171,829	332,067,918	95.10%	97.16%	102.85%	98.37%
Madera	3,152,761	3,159,232	1,652,217	2,316,334	2,522,015	1,190,422	73.47%	79.83%	72.05%	75.12%
Marin	1,887,593	2,425,800	2,838,314	1,871,737	2,942,738	2,732,729	99.16%	121.31%	96.28%	105.58%
Mariposa	225,260	211,481	226,770	264,207	232,735	227,564	117.29%	110.05%	100.35%	109.23%
Mendocino	3,448,722	3,888,902	4,811,008	3,296,978	4,172,403	4,686,884	95.60%	107.29%	97.42%	100.10%
Merced	1,942,953	2,578,617	2,891,602	1,977,149	2,667,837	3,003,796	101.76%	103.46%	103.88%	103.03%
Modoc	187,949	157,979	93,712	217,401	201,929	96,036	115.67%	127.82%	102.48%	115.32%
Mono	351,623	266,935	186,027	298,880	223,051	182,716	85.00%	83.56%	98.22%	88.93%
Monterey	6,161,724	9,230,584	9,269,704	4,780,265	8,596,443	9,088,945	77.58%	93.13%	98.05%	89.59%
Napa	1,749,427	1,691,233	1,535,994	1,465,495	1,581,810	1,251,989	83.77%	93.53%	81.51%	86.27%
Nevada	950,198	979,996	1,156,632	874,847	862,984	1,021,075	92.07%	88.06%	88.28%	89.47%
Orange	30,941,020	33,925,756	28,302,900	33,725,712	37,508,316	34,014,425	109.00%	110.56%	120.18%	113.25%
Placer	2,723,612	3,205,897	3,749,648	2,580,775	2,949,105	3,489,422	94.76%	91.99%	93.06%	93.27%
Plumas	426,867	457,275	587,216	365,227	358,549	436,067	85.56%	78.41%	74.26%	79.41%
Riverside	10,907,548	13,433,552	13,837,759	11,984,123	13,715,657	13,963,683	109.87%	102.10%	100.91%	104.29%
Sacramento	51,072,932	64,345,634	65,296,269	51,113,790	63,856,607	66,079,824	100.08%	99.24%	101.20%	100.17%
San Benito	602,496	804,622	816,532	460,126	480,842	571,654	76.37%	59.76%	70.01%	68.71%
San Bernardino	14,619,664	18,708,681	27,727,242	13,868,213	18,293,348	24,275,200	94.86%	97.78%	87.55%	93.40%
San Diego	49,611,402	56,748,708	53,054,391	40,185,236	47,300,048	45,425,170	81.00%	83.35%	85.62%	83.32%
San Francisco	13,872,684	16,596,730	15,604,247	12,396,630	14,986,847	13,879,978	89.36%	90.30%	88.95%	89.54%
San Joaquin	7,606,755	8,976,214	8,101,641	6,859,772	8,136,040	7,478,625	90.18%	90.64%	92.31%	91.04%
San Luis Obisp	5,098,008	4,333,939	4,377,450	4,285,386	4,042,698	4,162,955	84.06%	93.28%	95.10%	90.81%
San Mateo**	7,623,984	8,227,046	8,661,950	7,623,984	8,227,046	8,661,950	100.00%	100.00%	100.00%	100.00%
Santa Barbara	9,103,344	10,847,823	12,318,029	8,913,084	10,231,667	11,918,925	97.91%	94.32%	96.76%	96.33%
Santa Clara	25,016,133	32,132,218	29,829,955	22,757,176	28,941,489	26,751,504	90.97%	90.07%	89.68%	90.24%
Santa Cruz	7,494,257	9,751,778	11,321,497	5,782,569	7,157,805	8,664,342	77.16%	73.40%	76.53%	75.70%
Shasta	3,887,126	4,150,901	4,530,640	4,230,359	4,218,561	4,680,604	108.83%	101.63%	103.31%	104.59%
Sierra***	30,978	0	0	0	0	0				
Siskiyou	2,821,511	3,858,978	5,876,742	2,002,991	3,132,332	4,518,039	70.99%	81.17%	76.88%	76.35%
Solano	7,894,681	9,503,232	9,271,830	8,245,388	9,625,332	8,765,584	104.44%	101.28%	94.54%	100.09%
Sonoma	6,479,125	5,242,232	4,592,631	4,748,551	3,553,185	3,610,726	73.29%	67.78%	78.62%	73.23%
Stanislaus	10,663,052	11,959,166	12,436,263	10,411,404	11,780,974	11,799,526	97.64%	98.51%	94.88%	97.01%
Sutter/Yuba	3,249,150	4,186,980	4,460,048	3,119,834	3,347,909	4,233,478	96.02%	79.96%	94.92%	90.30%
Tehama	1,423,015	1,139,778	938,392	1,255,811	1,159,040	906,017	88.25%	101.69%	96.55%	95.50%
Trinity	424,818	254,565	503,627	465,388	226,894	497,382	109.55%	89.13%	98.76%	99.15%
Tulare	12,516,717	11,518,844	11,264,321	10,163,574	9,788,714	9,008,078	81.20%	84.98%	79.97%	82.05%
Tuolumne	1,161,330	1,161,551	1,072,736	1,032,074	1,111,024	1,077,885	88.87%	95.65%	100.48%	95.00%
Ventura	7,822,759	8,674,584	8,850,954	6,782,332	7,766,355	7,325,935	86.70%	89.53%	82.77%	86.33%
Yolo	4,454,468	4,419,317	3,756,440	4,263,817	4,457,323	3,934,120	95.72%	100.86%	104.73%	100.44%

Source: Statewide Average Percent Cost Settlement Spreadsheet provided by Mike McCourt, Associate Budget Analyst, Department of Mental Health.

DEPARTMENT RESPONSE

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

March 1, 2007

Diana L. Ducay, Chief
Office of State Audits and Evaluations
Department of Finance
300 Capitol Mall, Suite 801
Sacramento, CA 95814

Dear Ms. Ducay:

Thank you for your office's recent review of the Department of Mental Health's (DMH) estimation methodology for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program that was performed as part of a larger contracted review of several of DMH's accounting and administrative processes. As noted in your report, there were limitations in the scope and depth of the EPSDT review, and DMH is already working with your office to develop and complete a more thorough analysis of the EPSDT estimation and funds flow processes.

Please see our comments below in response to the four observation/ recommendation areas presented in your report; we provide additional information and offer clarification on issues of disagreement. Our goal is to improve the adequacy of the EPSDT forecast and cost estimate in order to avoid future general fund deficiencies. We intend to develop a strategic plan to address this estimation issue. Our approach will likely include engaging an independent consulting group.

Observation 1: *EPSDT Base Estimate Lacks Essential User and Service Type Components*

We agree that the EPSDT cost estimates have historically been calculated at the program level – and not at a more detailed level. However, DMH does use more detailed information for other analytic and explanatory purposes. At this point in time, DMH would also be able to provide cost estimates that include more granular detail with respect to service categories, regions, counties, user aid codes, as well as age, gender and racial/ethnic groupings. It may be the case that this type of itemization would be able to isolate what contributions the components are making to the overall variance, and thereby allow us to determine which component(s) may be most responsible for potential cost increases. However, the nature of the EPSDT program is all-inclusive in terms of the services delivered; thus, the distribution of services is likely to remain relatively uniform in the absence of significant policy change. We agree that the

itemization becomes important if a policy change can be numerically tied to a particular line item. For example, if there were policy that increased services to certain underserved culture-specific communities, we may see costs increase for particular racial/ethnic groups. However, previous experience has shown that some policies impact overall cost, while others may produce a shift in cost from one component area to another without affecting overall EPSDT cost. Therefore, it is difficult to know exactly how a policy change will impact overall cost. In order to clarify and understand these issues further, we intend to calculate estimates at a more detailed level based on the service categories and user breakouts referenced above.

DMH is also working with counties to improve their information systems; specifically there is a large effort underway on the part of counties to implement electronic health record systems and improve information exchange. Although counties currently use standard service definitions and report standard codes, electronic health record systems will further streamline this standardization and reporting. Additionally, claims will be able to be linked to detailed service records information, and counties will be able to report greater detail than they do currently. DMH is also evaluating how greater specificity can be achieved within the cost reporting system. These efforts coupled with training at the county level, will significantly improve uniformity, and increase the specificity available with respect to user and service type categories, thereby leading to better EPSDT estimates.

Observation 2: *Cost Settlement Adjustments Are Unreliable*

Two apparent contributions to the above conclusion are identified in the report:
1) Settled county claim amounts in some cases exceeded initial estimated approved claim amounts. The explanation of this provided by DMH was not adequate.
2) Steady, statewide increases in cost settled amounts are approaching initial estimated approved claims amounts, putting the discount factor into question.

Regarding #1, above: There are two clear factors that contribute to settled county claim amounts being different than initial county estimated, approved claim amounts. One factor is counties' ability to appeal disallowed claims, which results in increased payments to the counties above the estimated, approved claims amount. Another factor is that counties' initial estimated approved claim amounts are by definition, only estimates; counties may claim the Statewide Maximum Allowance (SMA) amount or any percentage thereof based on their best estimate of what local costs will actually be. It is expected that cost settled amounts will deviate somewhat (up or down) from the initial approved claims estimates. Because the initial approved claim amounts are estimates, counties may increase (or decrease) the claim amount after the service claim is approved (claim approval is based on service criteria; that is, medical necessity, eligibility, etc.). The deviation (increase or decrease) of actual county costs from their initial approved claims estimates is then reflected in the cost settled amount

approximately two years later. If counties do not initially claim enough to reflect their actual local cost, the settled cost will be higher than the initial estimated approved claims cost. The reverse is also true. Approved claims are necessarily point-in-time, interim payments, so that counties have available funds to provide continued services to clients.

The DMH cost reimbursement process and system for EPSDT is consistent with the state plan and our Medicaid waiver. However, DMH will be working to streamline and improve the claiming process in order to ensure timely payment and cost reconciliation, and to improve EPSDT cost estimates. Opportunities for streamlining and regulating the claims process are likely to be identified during the upcoming, in-depth OSAE analysis of the EPSDT issue that DMH is now contracting for. DMH hopes that this comprehensive OSAE analysis will yield helpful information toward improving its claiming processes.

Regarding #2, above: We agree with the observation that statewide cost settled amounts are approaching initial estimated approved claims amounts in recent years. This is actually a positive progression, since counties' ability to estimate actual costs in the interim claims process may be improving. As a consequence, the discount factor currently used may be in excess of what is appropriate, given our goal not to underestimate the EPSDT program cost. We intend to carefully examine the settled-to-approved claim trend and year-to-year increases in order to develop a more accurate discount factor. It may be that using a discount factor based on the most recent previous year's settled-to-approved claims information (rather than a past three-year average) will yield the most accurate estimation. The discount factor may be better named an *adjustment factor*, since the statewide cost settlement ratio could potentially exceed 100%, depending upon approved claims cost estimations at the county level (see paragraph above).

The report implies that DMH estimation processes should be analogous to those of the Department of Health Services' larger, Medi-Cal program. We must mention here that the payment processes between the two departments are not consistent; the Department of Health Services does not have a county estimated, approved claims payment process. Therefore, the estimation methods are necessarily based on different data.

The report also states, "The data from the county reporting systems and the Short-Doyle Medi-Cal (SDMC) system used by DMH to develop the cost settlement adjustment may be incompatible based on the excessive settlement ratios noted." It is not that the data are incompatible; they are separate systems with separate functions. The SDMC system provides estimated costs of individual service claims, while the county cost reporting system provides actual settled costs.

Observation 3: *Policy Changes to the EPSDT Program Are Not Adequately Assessed*

In contrast to what is stated in the report, DMH *does* take policy changes and decisions into account when formulating EPSDT estimates. There are a number of policy issues that have impacted EPSDT estimates. Examples include Mental Health Services Act (MHSA) activities (particularly outreach strategies) and the Emily Q. law suit. Other things that DMH may consider are future court orders, policy issues raised in the regulations process, such as adoption assistance and out-of-county placement policies, policy decisions stemming from recently passed legislation such as the memoranda of understanding required at the county level with regard to the AB 3632 (Mental Health Services for Children in Special Education), the Governor's healthcare proposal, mental health parity legislation, etc. As these are introduced and implemented, they have the potential to increase the number of EPSDT consumers or the amount of services that an EPSDT consumer receives, thereby potentially increasing the overall cost of the EPSDT program. Therefore, as these issues begin to impact EPSDT service delivery, they are certainly taken into account in the cost estimate. DMH will also continue to anticipate the impact of such policy issues.

Although policy information is clearly integrated into the EPSDT estimate, the absence of history in the case of some new policies does not allow us to estimate the policy's immediate impact in any numeric or formulaic way. Because there is no opportunity to model impact without past data/history, our estimates must often rely on current information and our best ability to anticipate the degree to which cost will be affected by new policies. In the case of MHSA impact, counties submitted their estimates, which DMH aggregated in order to estimate statewide EPSDT impact. However, counties did not implement a consistent formulaic estimation methodology. DMH will be providing future guidance to increase methodological consistency among counties.

Due to the lack of historical data with respect to new policies (mentioned above), DMH does not currently use a numeric mechanism to build most policy changes into the EPSDT estimate. However, DMH intends to look into ways of extrapolating cost information from other similar programs, for which historical data may be available. For example, we will be analyzing how we might use historical Medi-Cal cost data from our AB 3632 program to inform EPSDT cost estimates. Additionally, Exhibit III of the OSAE report mentions that the Department of Health Services has a Fiscal Analysis Unit that is responsible for quantifying the impact of policy changes. We intend to examine how this is accomplished, and potentially adopt such methods, if viable and applicable to our EPSDT program. DMH will likely require additional resources in order to implement this level of complexity in its estimation methods.

Observation 4: *Potential Increases in EPSDT Prevalence Rates Are Not Adequately Assessed*

In contrast to what is stated in the report, DMH *does* consider increases in capacity and service utilization potential in the EPSDT program. These are related to Medi-Cal beneficiary increases, policy changes, increases in mental health funding (e.g., MHSA), and expansion of services due to legislation, etc. (see above).

The extent of EPSDT growth as described in the report, although theoretically possible, is not probable. Service capacity limits would make any dramatic increases unlikely. Furthermore, population growth and other factors that lead to general Medi-Cal beneficiary increase would make a leap in penetration rate unlikely. The penetration rate is the ratio of Medi-Cal beneficiaries served, to the total number of Medi-Cal beneficiaries. If the total number of Medi-Cal beneficiaries increases, more beneficiaries will need to be served to achieve the same penetration rate. Therefore, as population and beneficiaries increase, counties serve increasingly more clients, while the penetration rate remains relatively consistent. It is already difficult for county mental health systems to keep pace with population growth and resulting beneficiary increase, and maintain the current penetration rate of approximately 5.5%. In other words, there will not be an increase in penetration rate even while counties serve more clients, as long as the total number of Medi-Cal beneficiaries increases respectively. It is important to point out here that DMH's current forecast methodology takes population and beneficiary increases into account.

It is also important to note that most of the consumers served through the EPSDT program are children/youth with serious emotional disturbance. The prevalence figures provided in the report, namely the 16-22%, likely refer to the entire population with any emotional or behavioral problems. EPSDT consumers are typically a severe child/youth subset that requires the array and intensive services offered through the EPSDT program. Although studies of prevalence continue to be informative, the prevalence rate of serious emotional disturbance (SED) with severe functional impairment is generally accepted by states to be 5-9%[1], which is consistent with the severe conditions served through the EPSDT program. Using a less stringent definition of impairment, prevalence figures range from 9%-13%[1] of the child/youth population, while an overall percentage figure of mental illness in children (ages 5-17) of 13.6% has been published[2].

Although the 5-9% range is likely to be the best estimate of the percentage of children/youth served in the EPSDT program, whether the 9% or higher 13.6% prevalence figure is used, growth of the EPSDT program to that level is not probable in the foreseeable future due to the capacity, funding, and population increase issues

[1] Costello, E.J., et al. (1998). The Prevalence of Serious Emotional Disturbance: A Re-Analysis of Community Studies, Journal of Child and Family Studies, Vol. 7, No. 4, pp. 411-432.
[2] Simpson, G.A., et al., Estimates of Attention, Cognitive, and Emotional Problems, and Health Service Use by US School-Age Children, Chapter 9, in Mental Health United States (2002). US DHHS, SAMHSA, CMHS.

mentioned above. The above clarifications having been noted, the example in the report does illustrate that there is potential for continued growth in the EPSDT program. We are aware of this fact and will continue to consider capacity, user and eligibility factors in our EPSDT cost estimation.

Thank you for the opportunity to comment on the report. We appreciate your review and recommendations related to our EPSDT estimation process. We are optimistic about the upcoming OSAE reviews of DMH's internal accounting and administrative controls, as well as the evaluation of all the local assistance claiming and payment processes, including Short Doyle/Medi-Cal programs and other allocation/grant payment processes. We anticipate opportunities for positive change as a result of these reviews.

Sincerely,

Original Signed By:

STEPHEN W. MAYBERG, Ph.D.
Director

EVALUATION OF RESPONSE

We have reviewed and evaluated the response provided by the Department of Mental Health (DMH), and incorporated the response into our final report. The response provides general information and clarification to our review of the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT); as well as identification of opportunities for improvement based on the observations. However, some of DMH's clarifications to the observations in the report did not include documentation to substantiate their assertions. The following are specific comments relating to the DMH's response for each observation:

OBSERVATION 1: EPSDT Base Estimate Lacks Essential User and Service Type Components

The DMH recognized that increasing the detail available with respect to user and service type categories may facilitate more accurate program estimates and improve accountability. The availability of relevant and timely expenditure detail is a critical component in establishing accountability within the program. DMH indicates they would be able to provide cost estimates that include more granular detail with respect to service categories, regions, counties, user aid codes, as well as age, gender, and racial/ethnic groupings. However, during our review, DMH did not provide evidence to substantiate this assertion, but instead noted challenges at the county level in implementing a uniform claim coding system that would allow DMH to extract more detailed relevant information at the component level.

The DMH states that, "the nature of the program is all-inclusive in terms of the services delivered, thus, the distribution of services is likely to remain relatively uniform in the absence of significant policy change." DMH also states that, "previous experience has shown that some policies impact overall cost, while others may produce a shift in cost from one component area to another without affecting overall EPSDT cost." DMH did not offer evidence to support these assertions; therefore, we maintain that evaluating and quantifying future policy changes is essential to the program estimate.

We encourage the DMH to continue working with counties to streamline the standardization and reporting of data so greater detail can be achieved. We continue to recommend that the DMH engage the services of an independent consulting group to make the long-term changes necessary to implement a more strategic approach to the current estimation process.

OBSERVATION 2: Cost Settlement Adjustments Should be Reevaluated

Throughout our review, the DMH offered inconsistent explanations of the origins, purpose, and relevance of the cost settlement factor. We appreciate the DMH's clarification for how paid claims can exceed approved claims. The primary concern is the accuracy of the discount factor being used by DMH and the observation has been revised accordingly. Also updated was an incorrect reference in the draft report. In Observation 2 a reference was made to Exhibit IV, this

should have been Exhibit V. The recommendation that DMH reevaluate the accuracy of the current discount factor in their estimate remains unchanged.

OBSERVATION 3: Policy Changes to the EPSDT Program Are Not Adequately Assessed

While we recognize the challenges of quantifying the effects of policy changes without historical data, we re-emphasize the importance of developing a methodology to quantify and incorporate future policy changes into the EPSDT estimate. The DMH states, "In contrast to what is stated in the report, DMH does take policy changes and decisions into account when formulating EPSDT estimates." We concur that the DMH takes policy changes and decisions into consideration. In fact our report states, "Historically, DMH has not adequately assessed policy changes to the EPSDT program and how changes will impact the EPSDT resources needed." The DMH cited the Mental Health Services Act (MHSA) as an example of incorporating policy change into the program estimate. We noted that the DMH was unable to explain or provide documentation to support the accuracy of these amounts. The DMH's response confirms the inadequate assessment of the MHSA impact by stating that the MHSA estimate formulation was inconsistently applied among counties.

The DMH also states that, "Due to the lack of historical data with respect to new policies, DMH does not currently use a numeric mechanism to build most policy changes into the EPSDT estimate." We reiterate our recommendation to develop a methodology, which would quantify and incorporate future policy changes into the program estimate.

OBSERVATION 4: Potential Increases in EPSDT Prevalence Rates Are Not Adequately Assessed

During our review, DMH could not provide evidence that they assess, quantify, and account for increases in capacity and service utilization in the EPSDT estimate. Therefore, the purpose of Observation 4 is to illustrate the potential growth to the EPSDT program and to emphasize the importance of monitoring user and caseload factors. We acknowledge that there is a wide variety of reports that cite different prevalence and penetration rates. While the response claims that our example may exaggerate the potential growth, the DMH does concur that there is a potential for continued growth in the EPSDT program. Therefore, we maintain that the DMH should monitor changes in caseloads, users, and other eligibility factors that may impact the program. Tracking costs at the user level as identified in Observation 1 will allow DMH to better monitor growth patterns.

We credit the DMH for their initial efforts in implementing some of our recommendations. We look forward to assisting the DMH in identifying additional opportunities during our upcoming internal control and local assistance program reviews.